Eligibility and Registration Form
Rural Transportation for Persons with Disabilities (PwD) Project

- Reduced fare transportation service may be available to you if you are:
  1. A person with a disability and
  2. Between 18 and 64 years old and
  3. Need accessible public transit in a participating county beyond ADA complementary paratransit services.

- If you would like to participate in this project, please complete this form and send it with a copy of one of the documents listed in Part 2 below to:

CCCT
1060 Lehigh Street
Allentown, PA 18103

- Once your application is received and reviewed you will be notified of your eligibility to participate.

- If you have questions about this project, this form or need this form in an alternate format please call:

570-669-6380 – 1-800-990-4287

Note: The information provided in this application regarding your disability will be used to determine your eligibility for reduced fare transportation services under the PwD project. Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and to provide you with the appropriate type of service**.** This information will be kept confidential and used only by professionals involved in evaluating your eligibility and in analyzing the pilot project for future recommendations. Please print clearly.

PART 1: GENERAL

Last Name: _____ First Name:_____ M.I.:_____

Address (Street & No.): _____

City: _____ State:_____ Zip Code: _____

Telephone: Home:_____ Work: _____ E-mail: _____

County of Residence: _____ Date of Birth: _____

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?

____ Yes ____ No

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disability Act (ADA). According to the ADA, "*Disability* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". "...*major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

PART 2: WRITTEN VERIFICATION THAT YOU ARE A PERSON WITH A DISABILITY

Written verification by a knowledgeable organization or qualified individual that you are a person with a disability is required to participate in the PwD project.

1. If you have written verification of a disability:

You may already have written verification that you are a person with a disability from a service organization by having an identification card, a written assessment of your disability, etc. If so, send a copy of this information to the transportation provider listed at the top of this form. If not, you will need to ask an organization or individual listed below to verify, in writing, that you are a person with a disability according to the ADA definition and then send it to the transportation provider listed at the top of page 1.

Please check the organization or individual whose written verification you are submitting with your application form.

_____ Office of Vocational Rehabilitation (OVR)

_____ Social Security Insurance (SSI) and Disability Insurance (SSDI)

_____ Bureau of Blindness and Visual Services

_____ Center for Independent Living (CIL)

_____ Mental Health/Mental Retardation Program

_____ United Cerebral Palsy

_____ Registered Physical/Occupational Therapist

_____ Physician

_____ Registered Nurse

_____ PA Attendant Care Program

_____ Community Services Program for Persons with Physical Disabilities

_____ Other: _____

_____

2. If you do not have written verification of a disability:

Please fill out a certification of disability form, Attachment F. It provides verification of a disability according to the definition in the Americans with Disabilities Act. This form can be used to acquire the necessary information for verifying a disability from a qualified health professional.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

Passenger income related data is being collected for further decision-making regarding the project. THIS INFORMATION WILL NOT BE USED TO DETERMINE ELIGIBILITY FOR DISCOUNTED FARES UNDER THE PwD PROGRAM. Please check the appropriate space in each column:

Annual Income

_____ Less than $10,000
_____ $10,001-$15,000
_____ $15,001-$20,000
_____ $20,001-$25,000
_____ $25,001-$30,000
_____ $30,000-$35,000
_____ $35,001-$40,000
_____ $40,001-$45,000
_____ $45,001-$50,000
_____ $50,001-$55,000
_____ $55,001-$60,000
_____ $60,001+

Household Size

_____ 1
_____ 2
_____ 3
_____ 4
_____ 5
_____ 6
_____ 7
_____ 8 +

PART 4: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the PwD project are not to be provided in place of any current transportation services that you already receive.

1. Do you now receive any transportation services or are any of your transportation costs paid for by another program or organization? Please complete all that apply from the following list.

_____ Senior Citizens Shared-Ride Transportation Program
_____ Area Agency on the Aging
_____ Medical Assistance Transportation Program
_____ Americans with Disabilities Act Complementary Paratransit
_____ Mental Health/Mental Retardation (MH/MR)
_____ Office of Vocational Rehabilitation (OVR)
_____ The training program I am in at _____
_____ The employment program I am in at _____
_____ The group home where I live.
_____ Other (please explain) _____

2. If you are not registered for Medical Assistance (MA), you may qualify. If appropriate, you will be referred to the County Assistance Office (CAO) for a determination of eligibility for MA and other programs.

_____ I have been informed of *pending referral* to the County Assistance Office (CAO)

_____ I was referred to the CAO for MA eligibility determination on (date): _____

Initials of staff person faxing the referral to the CAO _____

PART 5: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent? ____ Yes ____No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.)

2. If not, how long is it expected to last? _____

3. What is the nature of your disability? Check those that apply.

_____ Mobility disability (please see question 4 below)
_____ Vision disability
_____ Hearing disability
_____ Cognitive disability
_____ Mental disability
_____ Other — Please specify: _____

4. Please check all mobility aids that apply.

_____ Manual wheelchair _____ Crutches
_____ Power Wheelchair _____ Cane
_____ Motorized Scooter _____ Walker

5. Do you require the services of a personal care attendant or escort when you travel? (A personal care attendant or escort is a person that you need to assist you during the trip or at your origin or destination)

_____ Yes

_____ No

_____ Sometimes

Please describe when you need assistance: _____

_____

_____

6. Emergency Contact (Optional)

Name: _____

Relationship: _____

Phone (Home): _____ (Work): _____

7. Is there anything else you want us to know so we can serve you better? ____ Yes ____ No

If "Yes," please describe: _____

_____

_____

_____

_____

_____

PART 6: RELEASE OF INFORMATION and YOUR CERTIFICATION OF THE APPLICATION FORM

Release of Information

I give my permission to _____ to contact a health care or other professional that I designate for additional information to verify that I am a person with a disability.

Yes_____ No _____

_____

Your Signature or That of the Person Who Completed This Form Date

I understand that the purpose of this application is to determine if I am eligible to participate in the PwD project. I certify that the information contained in this application is correct and truthful to the best of my knowledge.

_____

Your signature or that of the person who completed this form Date

_____

Name of the person who completed this form Relationship Telephone number

Eligibility and Registration Form — Supporting Information

Medical Assistance Transportation Program (MATP) Eligibility Information

Documentation of Disabilities

Three Categories of Disabilities – Attachment A

1) Mental impairment, including development disabilities
2) Physical impairment
3) Major life activities

Samples of Forms Used for Determining that a Person has a Disability

1) Attachment B: Washington County Transportation Program (WCTP) form to be completed by physician or agency
2) Attachment C: Office of Vocational Rehabilitation Comprehensive Medical Examination form
3) Attachment D: Attendant Care Service form
4) Attachment E: OSP/Independence Eligibility Review form
5) Attachment F: Certification of Disability Form: To be used if an applicant has no written documentation of his/her disability

Attachment G: Federal Poverty Income Guidelines

Medical Assistance Transportation Program — Eligibility Guidelines

In keeping with the maintenance of effort policy of the PwD project, transportation providers and their subcontractors, if appropriate, are required to refer Medical Assistance Transportation Program (MATP) eligible clients to that program for funding for their medical trips.

The County Assistance Office (CAO) provides individuals who are eligible for MA with an ACCESS card. Eligibility for MA and MATP is confirmed through the Department of Public Welfare's computerized Eligibility Verification System or EVS. All MATP providers are required to verify a client's MATP eligibility through EVS, which can be accessed by telephone, a point of sale device, or through an EVS provided computer disk. MATP eligibility verification information must be recorded.

If a transit provider is not also the MATP coordinator, then the transit provider must request the MATP coordinator to check on a client's eligibility status through EVS or the client must be referred to the CAO for an assessment of MA eligibility. The transit provider must notify the client of his/her referral to the CAO prior to making the actual referral.

Clients of the PwD project, whose incomes indicate a possible eligibility for MA, must be referred to the CAO for a determination of eligibility for MA and other programs. A client who is determined eligible for MA is also eligible for the MATP. PwD providers must then refer them to the MATP for funding of their medical trips. Clients must also receive notification of the CAO referral in advance.

Documentation of Disabilities

The transit provider must obtain documentation of the disability as identified by the applicant. Transportation authorities that have established ADA eligibility determination procedures can use these procedures as a base for the pilot project's disability eligibility determination.

All agencies should accept the eligibility determinations and documentation that have been prepared by organizations and programs that interact with the disability community. **Examples** of these agencies and programs include the following:

- Social Security Administration's SSI and SSDI eligibility determinations and supporting documentation, such as a SSDI card.
- Washington County Transportation Program's (WCTP) disability determination form to be completed by a physician or agency. A copy of the form is provided as Attachment B.
- Office of Vocational Rehabilitation's (OVR) establishment of a mental or physical disability through its Comprehensive Medical Examination. A copy of this form is Attachment C.
- Attendant Care Program qualifying disability: any medically determinable physical impairment that can be expected to last for a continuous period of not less than 12 months. The standard form used by this program is included as Attachment D.
- A qualifying disability through the Community Services Program for Persons with a Physical Disability. A medically determinable condition, excluding primary diagnoses of mental retardation or mental illness, expected to continue indefinitely; and resulting in at least three of the following six substantial functional limitations: self care, understanding and use of language, learning, mobility, self direction, and capacity for independent living. This program's OSP/Independence Eligibility Review form is Attachment E.
- The Certification of Disability Form that has been developed for the pilot project. This form, which is Attachment F, provides verification that an applicant has a disability according to the definition in the Americans with Disabilities Act. If there is no organization available to provide the disability documentation, then the transit provider should use this form to acquire the necessary information for determining eligibility from a qualified medical provider.

The transit provider may also permit another agency to complete the Registration and Eligibility Form. This is acceptable if all of the necessary eligibility documentation is provided to the transit provider with the application.

Attachment A

Three Categories of Disabilities

Rural Transportation for Persons with Disabilities (PwD) Program

Disabilities are described in the following three categories:

1) Mental impairment, including development disabilities
   a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
   b. Is likely to continue indefinitely;
   c. Results in substantial functional limitations in any of the following areas of major life activities: self-direction, learning, mobility, economic self-sufficiency, self-care, capacity for independent living and receptive and expressive language;
   d. Causes the substantial diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, attention impairment, cognition impairment, language impairment, memory impairment, conduct disorder, or motor disorder.

2) Physical impairment
   a. Persons having a physical condition resulting from injury, disease, or congenital deficiency which significantly interferes with or limits one or more major life activities and affects one or more of the following body systems: anatomical, musculoskeletal, neurological, respiratory including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine;
   b. The term physical impairment includes but is not limited to such contagious or non-contagious diseases and conditions as orthopedic, visual, speech and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease and tuberculosis.

3) Major life activities
   a. Activities relating to the performance of self-care and engaging in leisure or play activities. Self-care includes grooming, mobility, object manipulation, and ambulation;
   b. Activities relating to the ability to walks, see, hear, breathe or communicate;
   c. Activities relating to moving about in one's community for purposes that include accessing and participating in vocational, educational, recreational, and social activities in the community with other members of the community.

Attachment B

Work Related Transportation for Persons with Disabilities

Sponsored by U.S. Department of Education & Washington County Department of Human Services

Application Date: ___/___/___

Please Print

Section I — Identifying Information

Name (Last, First, MI)	Date of Birth	Telephone No.
Address (Street, Apt. No., City, State, Zip Code)		County of Residence
Nearest Intersecting Road		Social Security No.
Work Address (Street, City, State, Zip Code)		Work Telephone No.

Section II — Work Related Eligibility Verification/Reverification

Individuals that might access this transportation service are as follows:

1. Persons who are current recipients of OVR vocational services.
2. Persons who have previously received OVR vocational services and/or persons currently receiving independent living or vocational rehabilitation services.
3. Other persons with disabilities needing transportation to employment (who have explored all other funding & transportation resources).

(check one)
- ❑ Reverification
- ❑ Verification

Disability Status
- ❑ Permanent
- ❑ Temporary until ___/___/___

Evidence of Disability
- ❑ Physician Verification (complete reverse side)
- ❑ Agency Verification (complete reverse side)
- ❑ Other _____

Nature of Disability
- ❑ Mobility Impaired
- ❑ Uses Wheelchair
- ❑ Uses Walker
- ❑ Vision Impaired
- ❑ Hearing Impaired
- ❑ Other _____

Section III — Determination of Need for Services

1. Is public transit (bus service) available within walking distance of your home?..... ❑ Yes ❑ No
2. Is there any other mode of transportation available to you?..... ❑ Yes ❑ No
3. Are you able to walk unassisted to the nearest bus stop?..... ❑ Yes ❑ No
4. Does an escort need to travel with you? ..... ❑ Yes ❑ No ❑ Sometimes
5. If you are in a wheelchair, can you transfer to the seat of a motor vehicle?..... ❑ Yes ❑ No
6. Are there any other effects of your disability of which we need to be aware? ..... ❑ Yes ❑ No

   If yes, please explain: _____
7. Explain any other reasons why you need specialized transportation:_____

   _____
8. Please explain any special directions needed to get to your residence:_____

   _____

Other Funding Services	❑ PennDOT 203	❑ Dept. of Aging	❑ Dept. of Welfare	❑ Other (explain):	
Mode	❑ Public Transit	❑ Shared Ride	❑ Private Auto	❑ Volunteer Service	❑ Other (explain):
Is Applicant Requesting	❑ Ongoing Regular Service		❑ One-time or Infrequent Service		
If Ongoing Service	How often are services needed_____ one way trips per _____ (mo/wk)				
Applicant's needs	Does the applicant require the use of an accessible vehicle? ❑ Yes ❑ No				
Other Information Service Needs					

Signature of Client or Designee	Date Signed

To Be Completed by Physician or Agency

I have examined/interviewed the applicant whose name appears on the reverse side of this form and believe that he or she needs special transportation because of the following disabling conditions:

❑ (1) Applicant is unable to ambulate sufficiently to walk ¾ mile.

❑ (2) Applicant is unable to walk up to three steps that are necessary to board a public transit vehicle.

❑ (3) If applicant uses a wheelchair, can he/she transfer to a seat of an automobile? ❑ Yes ❑ No

❑ (4) The applicant cannot stand without major support in a moving vehicle operating under normal acceleration and deceleration.

❑ (5) Due to uncorrectable vision impairment, the applicant cannot read vehicle identification or identify transit stops.

❑ (6) Due to uncorrectable hearing impairment, the applicant cannot hear vehicle announcements or transit information through either direct personal or electronic communications.

❑ (7) Due to physical or mental conditions, the applicant cannot access public transit without the help of another person or special training.

❑ (8) Due to physical or mental conditions, the applicant cannot travel to or from a regular bus stop to use public transit.

❑ (9) Does applicant need any specialized transportation service such as wheelchair lifts, etc? ❑ Yes ❑ No

❑ (10) Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Section IV — Affirmation of Information

I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete. I agree to report any changes in circumstance immediately to the service provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that knowingly giving false statements is a criminal offense. I understand that I have a right to request a Department of Public Welfare fair hearing. This affirmation statement covers all attachments required for determination of eligibility.

Signature of Client or Designee	Date Signed

Reason for Signature if Other than Applicant			
Interviewer's Name (please print)	Phone Number	Signature of Interviewer	Date Signed

Agency Determining Eligibility
Address (Street, City, State, Zip Code)
Agency Providing Transportation Service
Address (Street, City, State, Zip Code)

Expiration Date: ___/___/___ Initials: _____	Data Input Date: ___/___/___ Initials: _____

Attachment C

Commonwealth of Pennsylvania
Department of Labor and Industry

OVR D.O. Stamp

_____
Social Security Number

_____
Client Number

_____
Date of Birth

Comprehensive Medical Examination

Section I — Counselor's Summary

_____ S__ M__ W__ D__ Sep__
Last Name First Middle Sex Marital Status

_____
Address: Street and Number City State Zip Code

Usual Occupation _____ Description and Date of Last Job _____

_____

Past Hospitalization _____

Client's Statement of Disability _____

_____

Client's Statement of Treatment Given _____

_____

_____
Counselor's Signature Date

Section II — Physician's Report

Past Medial History _____

_____

_____

History of Present Illness or Disability _____

_____

_____

_____

_____

Section III — Physical Examination

Blood Pressure_____ Pulse_____ Respiration_____ Height_____ Weight_____

Vision (Distant) R: 20/____ L: 20/___ with Glasses: R: 20/____ L: 20/___

Hearing: R. 15/___ L. 15/___

	Normal	Describe Abnormality
1. EYES (discharge, strabismus, pteygium, pyosis, fundi, cataract, etc.)		
2. EARS (evidence of deafness, middle ear or mastoid disease, drums: absent, perforated, dull, retracted, discharge)		
3. NOSE (obstruction, evidence of chronic sinus, infection, polyp.)		
4. THROAT (tonsils: enlarged, removed)		
5. MOUTH (missing teeth, pyorrhea, caries, abnormal tongue or palate)		
6. NECK (thyroid enlargement, nodules, masses)		
7. BREASTS (abnormal discharge, nodules, tenderness)		
8. LUNGS (conformation, respiratory movement, breath sounds, rales, dullness)		
9. HEART (enlargement, thrills, murmurs, rhythm, dyspnoea, cyanosis, edema)		
10. ARTERIES (peripheral pulsations)		
11. VEINS (varicose: location, severity)		
12. ABDOMEN (scars, masses, palpable liver or spleen, tenderness)		
13. HERNIA (size, type, severity)		
14. GENITALIA—MALE (discharge, varicocele, hydrocele, prostate)		
15. GYNECOLOGICAL (describe significant abnormal condition, severity and extent)		
16. ANO-RECTAL (severity and extent of hemorrhoids, prolapse, fissures, fistula, etc.)		
17. NERVOUS SYSTEM (gait reflexes, sensation, paralysis, speech, etc.)		
18. PHYCHIATRIC (mood, abnormal behavior, etc.)		
19. SKIN (lesions, scars, abnormalities — extent and severity)		
20. ORTHOEDIC (congenital or acquired impairments, feet, back, amputations, etc.)		

Section IV — Laboratory

Urinalysis: S.G. _____ Albumen _____ Sugar_____

Serology Indicated: Yes. _____ No _____

Section V — Clinical Impressions (Diagnosis): (What are the limitation of activities?)

_____

_____

_____

(A) If disability prevents employment in the labor market, will medical and or surgical treatment increase patient's chance for other gainful activities, including homemaking duties? Yes_____ No_____

(B) Indicate additional laboratory procedures and/or specialty examinations you would recommend.

_____

_____

Physician's Signature Date Physician (Print Name)

Street Address:

Send copy of specialty examinations? Yes___ No___ City, State, Zip

Attachment D

Application for Attendant Care Services

Consumer Information

Name of Consumer (Last, First, Middle)			Date	
Address (Street, Apt. No., City, State)			Zip Code	County
Telephone No.	Birth Date	Sex	Social Security Number	

Disabilities	Date of Onset
	Date of Onset

❑ Yes ❑ No Do you expect your physical disability(s) to last for a continuous period of not less than 12 months?

❑ Yes ❑ No Are you capable of selecting, supervising, and if needed, firing an attendant?

❑ Yes ❑ No Are you capable of managing or directing other to manage your own financial and legal affairs?

❑ Yes ❑ No Do you require assistance to complete functions of daily living, self care, and mobility in the following:
(If yes, check all that apply)

❑ Bowel, bladder or other bodily functions	❑ Grooming	❑ Transfers	❑ Meal Preparation	❑ Ambulation
	❑ Dressing	❑ Consumption of food	❑ Bathing	❑ None of the above

❑ Other:

❑ Yes ❑ No Are you currently receiving attendant care or other in-home services from another agency?
(If yes, specify)

Explain your need and reason for applying for attendant care services.

Provider Information

Name of Provider Agency	M.A. ID
Name of Provider Representative Completing this Form	Telephone No.

❑ Yes ❑ No Is the consumer's name listed on a valid PA Access card?

If yes, show PA Access card (information recipient number and card issue number) and enter zero (0) under weekly fee	
Recipient Number	Card Issue Number

Family Composition

Name Last, First, M.I. (include applicant)	**Relationship**	**Source of Income**	**Monthly Gross Income**
Total Family Size **»**		Total Monthly Income **»**	
		Less Medical Expense Deduction **»**	
		Adjusted Monthly Income **»**	
		Weekly Fee **»**	

Medical Expense Deductions

Monthly Total: $ _____

Affirmation of Information

I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete. I agree to report any changes in circumstances immediately to this service provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes. I understand that I have a right to request a department of public welfare fair hearing. This affirmation statement covers both sides of this form and all attachments required for the determination of eligibility under the attendant care program.

_____

Signature of consumer

Attachment E

OSP/OBRA Waiver Eligibility Review

		Date
Consumer's Name		Social Security Number
Age	County of Residence	Referral Source
Primary Dx		Secondary Dx

A. General Exceptions

	Yes	No
1. Is the consumer under the age of 18?		
2. Is the consumer comatose?		
3. Is the consumer ventilator dependent?		
4. Is the consumer terminally ill?		
5. Does the consumer function at the brain stem level?		
6. Does the consumer have a diagnosis of Alzheimer's or any other dementia?		
7. Do service costs exceed current cost of nursing facility placement?		

B. Mental Retardation Exceptions

	Yes	No
1. Does the consumer have a past or current primary Dx of mental retardation?		
2. Does the consumer have a documented IQ below 70?		
3. Does the consumer receive services through an MR waiver?		
4. Does the consumer have severe deficits in adaptive behavior?		

C. Mental Illness Exceptions

	Yes	No
1. Does the consumer have an official CURRENT Dx of a major mental disorder?		
2. Has the consumer been hospitalized more than once within the past two years for psychiatric treatment more intensive than outpatient psychiatric care?		
3. Within the past two years, has the consumer experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in residential treatment, or which resulted in intervention by housing or law enforcement officials?		
4. Is there presenting evidence of suicidal or homicidal ideation?		
5. Is there presenting evidence of hallucinations or delusions?		

D. Exceptions

If any of the above are checked "yes," the consumer is not eligible unless justification can be provided in the comments section below:

E. Three Substantial Functional Limitations

Please check either "yes" or "no" to indicate whether the consumer has a substantial functional limitation in each of the six areas listed below. In addition, for those areas checked "yes," please provide comments to substantiate the claim.

	Yes	No
1. Self Care: A person who has a condition, which requires that person to need significant assistance to look after personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of the time of all activities normally required for self-care.		
Comments		

	Yes	No
2. Communication: A person who has a condition, which prevents that person from effectively communicating with another person without the aid of a third person, a person with special skills, or with a mechanical device, or a long-term condition which prevents him or her from articulating thoughts.		
Comments		

	Yes	No
3. Learning: A person who has a condition, which seriously interferes with cognition, visual, or aural communication, or use of hand to the extent that special intervention or special programs are required to aid that person in learning.		
Comments		

	Yes	No
4. Mobility: A person who has a condition which impairs the ability to use fine and/or gross motor skills to the extent that assistance of another person and/or mechanical device is needed in order for the individual to move from place to place.		
Comments		

	Yes	No
5. Self-direction: A person who has a condition which requires that person to need assistance in being able to make independent decisions concerning social and individual activities and/or handling personal finances and/or protecting his/her own self-interest.		
Comments		

	Yes	No
6. Capacity for Independent Living: A person who has a condition which limits that person from performing normal societal roles or which makes it unsafe for that person to live alone to such an extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).		
Comments		
If three or more substantial functional limitations are not indicated, the consumer is not eligible.		

F. Attendant Care Program Screening

	Yes	No
Can the Attendant Care Program appropriately serve the consumer?		
Comments		

Please indicate whether or not the consumer had habilitation needs that if it were not for Waiver services, he or she would quality for ICF/ORC level of care. Please list the consumer's needs that qualify him/her for ICF/ORC level of care.

H. Nursing Facility and Medical Assistance Eligible

	Yes	No
1. Is it anticipated that the consumer will be eligible for Medical Assistance?		
2. Is it anticipated that the consumer will be eligible for nursing facility services?		

I. Final Eligibility Screen

	Yes	No
1. Is there sufficient information about the consumer to determine general eligibility for the OSP/OBRA waiver (pending MA and OSP's determinations)?		

If "no" is checked, indicate additional information required to determine initial eligibility:

J. Referrals

Based on information provided, the consumer is not eligible for the OSP/OBRA. As a result, referrals were made to the following:

1.

2.

3.

Attachment F

Certification of Disability Form

Reduced Fare Transportation Services
Rural Transportation for Persons with Disabilities (PwD) Program

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. This form is to be completed by a profession who is familiar with the applicant's disability. A professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services to people with disabilities. The applicant has applied for transportation services under the Rural Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by Carbon County Community Transit (CCCT). If you have any questions about the form, please call 570-669-6380 or 800-990-4287.

Applicant Information (to be completed by applicant):

Last Name: _____ First Name: _____ M.I.: _____

Address (Street & No.):_____

City:_____ State: _____ Zip Code: _____

Telephone: Home: _____ Work:_____ E-mail: _____

_____
Applicant signature or that of the person who completed this form Date

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disability Act (ADA). According to the ADA, "*Disability* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". "...*major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

Please answer the following questions (**to be completed by the agency or person providing verification of eligibility information**)

Is the applicant's disability permanent? ____ Yes ____No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.)

If not, how long is it expected to last? _____

What is the nature of the applicant's disability? Check those that apply.

_____ Mobility disability (please see question to the right)
_____ Vision disability
_____ Hearing disability
_____ Cognitive disability
_____ Mental disability
_____ Other — Please specify:_____

Please check all mobility aids that apply.

_____ Manual wheelchair _____Crutches
_____ Power Wheelchair _____Cane
_____ Motorized Scooter _____Walker

_____
Signature of Professional Date

_____
Title Name of Agency or Organization

_____
Address Telephone

Please send completed form to:

CCCT
1060 Lehigh Street
Allentown, PA 18103

ATTACHMENT G

250% of the 2002 Federal Poverty Income Guidelines

Family Size	Monthly Limit	Annual Limit
1	$1846	$22,150
2	$2488	$29,850
3	$3130	$37,550
4	$3771	$45,250
5	$4413	$52,950
6	$5055	$60,650

Submitted by the DPW Office of Policy Development Jan. 2003